MENTALLY RETARDED DEFENDANTS: DIVERSION

1. Summary of Chapter 1253/80

Under prior law, if a criminal defendant was found to be mentally incompetent to stand trial and is developmentally disabled, the criminal judicial process was suspended and the defendant was assigned to a state hospital or other available residential facility. Upon restoration of the defendant's competency, the criminal judicial process was resumed.

This Chapter establishes a procedure whereby a mentally incompetent and developmentally disabled defendant, who was charged with a misdemeanor or who's charges were reduced to a misdemeanor and successfully completes a diversion program shall have the criminal charges dropped. Prior to diversion by the court, the district attorney, probation department and regional center for the developmentally disabled are required to submit a report to the court which would contain a recommendation on the defendant's diversion.

2. Eligible Claimants

Any county that has incurred increased costs as a result of this mandate is eligible to claim reimbursement of costs.

3. Types of Claims

A. Reimbursement Claims

A reimbursement claim is defined in GC Section 17522 as any claim filed with SCO by a county for reimbursement of costs incurred for which an appropriation is made for the purpose of paying the claim.

An actual claim may be filed by February 15 following the fiscal year in which costs were incurred. If the filing deadline falls on a weekend or holiday, the filing deadline will be the next business day. Since the 15th falls on a weekend in 2009 claims for fiscal year 2007-08 will be accepted without penalty if postmarked or delivered on or before February 17, 2009. Claims filed after the deadline will be reduced by a late penalty of 10%, not to exceed $10,000. A claim filed more than one year after the deadline cannot be accepted for reimbursement.

In order for a claim to be considered properly filed, it must include the Indirect Cost Rate Proposal (ICRP) if the indirect cost rate exceeds 10%. A more detailed discussion of the ICRP may be found in Section 8 of the instructions.

Documentation to support actual costs must be kept on hand by the claimant and made available to the SCO upon request as explained in Section 17, of the instructions.

B. Estimated Claims

Pursuant to AB 8, Chapter 6, Statutes of 2008, the option to file estimated claims has been eliminated. Therefore, estimated claims filed on or after February 16, 2008, will not be accepted by SCO

4. Reimbursable Components

Eligible claimants will be reimbursed for increased costs associated with the changes in the adjudication process for defendants who are both mentally incompetent and developmentally disabled. Specifically, Penal Code Sections 1001.22(b), 1001.22(c) and 1001.28(a) required the district attorney and probation officer to prepare specific reports and reports on related court hearings.

A. District Attorney Services

The District Attorney's cost of preparing reports, as required by Penal Code Section 1001.22(b) and related hearings is reimbursable.

B. Probation Department Services

The cost of the probation officer for preparing reports as required by Penal Code Sections 1001.22(c) and 1001.28(a) and related court hearings is reimbursable.

5. Reimbursement Limitations

Any offsetting savings or reimbursement the claimant received from any source, as a result to this mandate, must be deducted from the amount claimed.

6. Claiming Forms

A. Form 2, Activity Cost Detail

This form is used to segregate the detail costs by claim component. A separate form 2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

1. Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed and specify the actual number of hours devoted to each function, the productive hourly rate and the related fringe benefits.

Source documents required to be maintained by the claimant may include, but are not limited to, employee time records that show the employee's actual time spent on the mandate.

2. Materials and Supplies

Only expenditures that can be identified as a direct cost of the mandate can be claimed. List cost of materials that have been consumed or expended specifically for the purpose of this mandate.

Source documents required to be maintained by the claimant may include, but are not limited to, invoices, receipts, purchase order and other documents evidencing the validity of the expenditures.

Pursuant to GC section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency or school district pursuant to this chapter is subject to the initiation of an audit by the SCO no later than three years after the date that the actual reimbursement claim is filed or last amended, whichever is later. However, if no funds are appropriated or no payment is made to a claimant for the program for the fiscal year for which the claim is filed, the time for the Controller

to initiate an audit shall commence to run from the date of initial payment of the claim. In any case, an audit shall be completed not later than two years after the date that the audit is commenced.

All documents used to support the reimbursable activities must be retained during the period subject to audit. If an audit has been initiated by the SCO during the period subject to audit, the retention period is extended until the ultimate resolution of any audit findings. Supporting documents shall be made available to the SCO on request.

B. Form 1, Claim Summary

This form is used to summarize direct costs by claim component and compute allowable indirect costs for the mandate. Claim statistics shall identify the amount of work performed during the claim period for which costs are claimed. The claimant must show the following: (1) the number of cases processed by the district attorney's office, and (2) the number of cases processed by the probation department. Direct costs on this form are carried forward from form MRD-2

Indirect costs may be computed as 10% of direct labor, excluding fringe benefits and the cost of supervision above the first level. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have their own ICRP.

C. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the county. All applicable information from form MRD-1 must be carried forward to this form in order for the State Controller's Office to process the claim for payment.

D. Form FAM-43, Entitlement Claim

This form is used to certify the actual costs incurred for a fiscal year for the purpose of establishing a base year entitlement. No payment is made for an entitlement claim.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561

MENTALLY RETARDED DEFENDANTS: DIVERSION

For State Controller Use Only	Program
(19) Program Number 00066	066
(20) Date Filed ____/____/____	
(21) LRS Input ____/____/____	

LABEL HERE

(01) Claimant Identification Number

(02) Claimant Name

County of Location

Street Address or P.O. Box Suite

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) **20___/20___**	(12) **20___/20___**
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Prior Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data	
(22) MRD-1, (03)(1)	
(23) MRD-1, (03)(2)	
(24) MRD-1, (04)(1)(d)	
(25) MRD-1, (04)(2)(d)	
(26) MRD-1, (06)	
(27) MRD-1, (07)	
(28) MRD-1, (09)	
(29) MRD-1, (10)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	

(37) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code §17561, I certify that I am the officer authorized by the local agency to file mandated cost claims with the State of California for this program, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1098, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein, and such costs are for a new program or increased level of services of an existing program. All offsetting savings and reimbursements set forth in the Parameters and Guidelines are identified, and all costs claimed are supported by source documentation currently maintained by the claimant.

The amounts for this Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs set forth on the attached statements. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Authorized Officer Date

Type or Print Name Title

(38) Name of Contact Person for Claim

Telephone Number **( ) - Ext.**

E-Mail Address

Program 066	MENTALLY RETARDED DEFENDANTS: DIVERSION Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) Enter your Official Name, County of Location, Street or P. O. Box address, City, State, and Zip Code.

(03) If filing an estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing a combined estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended estimated claim, enter an "X" in the box on line (05) Amended.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of the estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form MRD-1 and enter the amount from line (11). If more than one form is completed due to multiple department involvement in this mandate, add line (11) of each form.

(08) Enter the same amount as shown on line (07).

(09) If filing a reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing a combined reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended reimbursement claim, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of the reimbursement claim from form MRD-1, line (11). The total claimed amount must exceed $1,000.

(14) Reimbursement claims must be filed by January 15 of the following fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter zero if the claim was timely filed, otherwise, enter the product of multiplying line (13) by the factor 0.10 (10% penalty), or $1,000, whichever is less.

(15) If filing a reimbursement claim and a claim was previously filed for the same fiscal year, enter the amount received for the claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16), Net Claimed Amount, is positive, enter that amount on line (17), Due from State.

(18) If line (16), Net Claimed Amount, is negative, enter that amount on line (18), Due to State.

(19) to (21) Leave blank.

(22) to (36) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (36) for the reimbursement claim, e.g., MRD-1, (03)(1), means the information is located on form MRD-1, block (03), line (1). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, i.e., no cents. Indirect costs percentage should be shown as a whole number and without the percent symbol, i.e., 35.19% should be shown as 35. **Completion of this data block will expedite the payment process**.

(37) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer, and must include the person's name and title, typed or printed. **Claims cannot be paid unless accompanied by an original signed certification**. **(To expedite the payment process, please sign the form FAM-27 with blue ink, and attach a copy of the form FAM-27 to the top of the claim package.)**

(38) Enter the name, telephone number, and e-mail address of the person to contact if additional information is required.

SUBMIT A SIGNED ORIGINAL, AND A COPY OF FORM FAM-27, WITH ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
MENTALLY RETARDED DEFENDANTS: DIVERSION

For State Controller Use Only

(19) Program Number 066
(20) Date Filed _____/_____/_____
(21) LRS Input _____/_____/_____

Program 066

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Base Year	Fiscal Years	FAM-27	Amount
First	(03)	(06) ☐	(09)
Second	(04)	(07) ☐	(10)
Third	(05)	(08) ☐	(11)

Entitlement Claim

(15) MRD-1, (03)(1)	
(16) MRD-1, (03)(2)	
(17) MRD-1, (04)(1)(d)	
(18) MRD-1, (04)(2)(d)	
(19) MRD-1, (06)	
(20) MRD-1, (07)	
(21) MRD-1, (09)	
(22) MRD-1, (10)	
(23)	
(24)	
(25)	
(26)	
(27)	
(28)	
(29)	
(30)	

(31) CERTIFICATION OF CLAIM

In accordance with the provisions of Article 5 (commencing with Section 17615) of Chapter 4 of Part 7 of Division 4 of Title 2 of the Government Code, I certify that I am the officer authorized by the county to file claims with the State of California for costs mandated by Chapter 1253, Statutes of 1980; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 through 1096 inclusive.

I further certify that there was no application for any grant or payment received, other than from the claimant, for costs contained herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1253, Statutes of 1980.

The amount of Entitlement Claim is hereby submitted to the State for the sole purpose of establishing or adjusting a base year entitlement of the mandated program of Chapter 1253, Statutes of 1980, set forth on the attached statement.

Signature of Authorized Officer Date

Type or Print Name Title

(39) Name of Contact Person for Claim

Telephone Number (_____) _____ - _____ Ext. _____

E-mail Address

Program 066	MENTALLY RETARDED DEFENDANTS: DIVERSION Certification Claim Form Instructions	FORM FAM-43

NOTE: Chapter 1534, Statutes of 1985, established the State Mandates Apportionment System (SMAS), a method of paying designated mandated programs as apportionments. This program is included in the SMAS. A claimant who has established a base year entitlement for this program will receive an annual payment by January 15 from the State Controller's Office. A base year entitlement is determined for each district by averaging their approved claims, (i.e., actual costs) 1981-82, 1982-83, and 1983-84 fiscal years or any three consecutive fiscal years thereafter. If a claimant has incurred costs for three consecutive fiscal years, but has not filed a claim for each of those years, the claimant may file an entitlement claim with the State Controller's Office. An entitlement claim is filed solely for the purpose of establishing a base year cost and may be filed for any or all of the three fiscal years. Once a base year entitlement has been established, no additional claim need to be filed by the claimant. Submit a separate form FAM-43 for each fiscal year that is needed to complete the three consecutive fiscal years.

(01) Leave blank.

(02) Enter the claimant's name, county in which claimant is located, street address, city, state, and zip code.

(03) to (05) Enter the three consecutive fiscal years that comprise the base year.

(06) to (08) If a form FAM-27 was filed for any fiscal year, enter an "x" in the box for that fiscal year.

(09) to (11) Enter the amount from form MRD-1, line (12) that corresponds to the fiscal year for this Entitlement Claim. Only one amount should appear on lines (09) through (11). Complete a separate FAM-43 for each entitlement claim. Do not enter an amount for the fiscal year in which a FAM-27 was previously filed as indicated in the checked box.

(12) to (14) Leave blank.

(15) to (30) Bring forward cost information as specified on the left-hand column of lines (15) through (19) for the reimbursement , e.g., MRD-1, (03)(1), means the information is located on form MRD-1, block (03), line (1) Enter the information in the left-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect cost percentage should be shown as a whole number without the percent symbol (i.e., 34.548% should be shown as 35). Completion of this data block will expedite the payment process.

(31) Read the statement entitled "Certification of Claim". If the statement is true, the claim must be dated, signed by the entity's authorized officer and must include the person's name and title, typed or printed. **Claims cannot be paid unless accompanied by a signed certification.**

(32) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED, ORIGINAL FORM FAM-43 WITH ALL OTHER FORMS AND SUPPORTING DOCUMENTS (NO COPIES NECESSARY) TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

Program 066	MANDATED COSTS MENTALLY RETARDED DEFENDANTS: DIVERSION CLAIM SUMMARY	FORM MRD-1

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	20___/20___
	Entitlement ☐	

Claim Statistics

(03) Number of Cases Processed:	
1. District Attorney	
2. Probation Department	

Direct Costs	**Object Accounts**			
(04) Reimbursable Components	(a) Salaries	(b) Benefits	(c) Services and Supplies	(d) Total
1. District Attorney Services				
2. Probation Department Services				
(05) Total Direct Costs				

Indirect Costs

(06) Indirect Cost Rate	[From ICRP]	%
(07) Total Indirect Costs	[Line (06) x line (05)(a)] or [line (06) x {line (05)(a) + line (05)(b)}]	
(08) Total Direct and Indirect Costs	[Line (05)(d) + line (07)]	

Cost Reduction

(09) Less: Offsetting Savings, if applicable	
(10) Less: Other Reimbursements, if applicable	
(11) Total Claimed Amount [Line (08) - {line (09) + line (10)}]	

Program 066	MENTALLY RETARDED DEFENDANTS: DIVERSION CLAIM SUMMARY Instructions	FORM MRD-1

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form MRD-1 must be filed for a reimbursement claim. Do not complete form MRD-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form MRD-1 must be completed and a statement attached explaining the increased costs. Without this information the estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) Enter the number of cases processed by the District Attorney and the number of cases processed by the Probation Department.

(04) Reimbursable Components. For each reimbursable component, enter the total from form MRD-2, line (05), columns (d), (e), and (f) to form MRD-1, block (04), columns (a), (b), and (c) in the appropriate row. Total each row.

(05) Total Direct Costs. Total columns (a) through (d).

(06) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits, without preparing an ICRP. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim.

(07) Total Indirect Costs. If the 10% flat rate is used for indirect costs, multiply Total Salaries, line (05)(a), by the Indirect Cost Rate, line (06). If an ICRP is submitted and both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (05)(a), and Total Benefits, line (05)(b), by the Indirect Cost Rate, line (06). If more than one department is reporting costs, each must have its own ICRP for the program.

(08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(d), and Total Indirect Costs, line (07).

(09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(10) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10), from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

PROGRAM 066	MANDATED COSTS MENTALLY RETARDED DEFENDANTS: DIVERSION COMPONENT/ACTIVITY COST DETAIL	FORM MRD-2

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Components: Check only **one** box per form to identify the component being claimed.

☐ District Attorney Services ☐ Probation Department Services

(04) Description of Expenses: Complete columns (a) through (f).

(a) Employee Names, Job Classifications, Functions Performed, and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	**Object Accounts** (d) Salaries	(e) Benefits	(f) Services and Supplies
(05) Total ☐ Subtotal ☐ Page:____of____					

Program 066	MENTALLY RETARDED DEFENDANTS: DIVERSION COMPONENT/ACTIVITY COST DETAIL Instructions	FORM MRD-2

(01) Enter the name of the claimant.

(02) Enter the fiscal year for which costs were incurred.

(03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form MRD-2 shall be prepared for each applicable component.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contract services and travel expenses. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than three years after the date the claim was filed or last amended, whichever is later. If no funds were appropriated and no payment was made at the time the claim was filed, the time for the Controller to initiate an audit shall be from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

Object/ Sub object Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits	Title Activities	Benefit Rate			Benefits = Benefit Rate x Salaries		
Services and Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Used	

(05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/activity costs, number each page. Enter totals from line (05), columns (d), (e), and (f) to form MRD-1, block (04), columns (a), (b), and (c) in the appropriate row.